Electronic Billing

Washington State Department of Labor and Industries

UB92 Format Flat File 5.0

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Overview

Electronic transfer billing is available to all providers of services to injured workers, whether you use the UB92, HCFA-1500, Labor and Industries Statement for Miscellaneous Services, Labor and Industries Statement for Pharmacy Services, or the Labor and Industries Statement for Home Nursing Services bill forms.

Methods of billing the Department electronically are varied, and can be broken down into two basic methods. You may either batch your bills and send them directly to us for entry into our system, which requires customized programming on your system, or use a clearinghouse/intermediary to send your bills to us for you. We do not supply software for this purpose. Internet usage is currently not an option.

Also, if you are inquiring about pharmacy billing, we now have a Point of Service system that allows you to enter your bills in real-time and get an accepted/rejected notification immediately. For more information on this system, please call our Provider Hotline at 1.800.848.0811.

For more information, please see our Website at http://www.lni.wa.gov/hsa/payment.htm.

Benefits to the Provider Using Electronic Billing

- Faster turn around time and more accurate processing of bills are the major advantages of electronic billing. This results in improved cash flow.

- You control when your bills are entered into the Medical Information and Payment System (MIPS). Electronic bills bypass many paper bill-processing steps (i.e. bill sorting, microfilming and data entry). Your bill data, formatted to the Department's specifications, is entered directly into MIPS. This eliminates the possibility of keying errors during data entry. In addition, the cutoff schedule for electronic bills allows for maximum adjudication before the end of the payment cycle.

- Your staff time is reduced in preparing bills and decreases the flow of paper through your office. Reduced paper handling lowers processing and postage costs.

- Less information is required. Data elements **not** required on electronic bills include: billing provider address, referring physician name and bill date, patient's first name, middle initial, address and employer, as well as narrative descriptions of procedures and diagnoses. This information is provided by MIPS.

- When you bill electronically we also offer you the option of receiving your Remittance Advice electronically, which adds to your full office management program.

Paper Bills vs. Electronic Bills

Paper Bill Processing

Paper bills received by L&I are screened for basic required information. Acceptable bills are batched by bill type, microfilmed, assigned an internal control number and then placed on a shelf in the order received. Due to the large volume of paper bills received, they may wait several weeks before being entered into the system.

Approximately 70 percent of all paper bills are either paid or denied upon entry. Suspended bills are held in the system pending final adjudication. These are usually processed to a final status within three to five weeks.

The payment cycle is two weeks with a cutoff every other Friday. Bills entered by our data entry staff by 4:30 p.m. on Friday appear on our Remittance Advice mailed the following week. Due to the paper bill process, providers have little control over whether or not their bills will be entered before the cutoff.

Processing Electronic Bills

Bills submitted by electronic media allow you to control when your bills are processed. Bill data received prior to 11:30 a.m., Monday through Friday, will appear in MIPS the following business day at 7:00 a.m.

Generally, a greater percentage of electronic bills are paid or denied upon entry into MIPS than those submitted on paper. MIPS is able to auto-process many of the bills due to fewer errors.

Payment cycles for electronic bills are the same as paper bills, except the cutoff is every other Tuesday at 12:00 p.m. instead of Friday. Bill data received by noon on the cutoff Tuesday is given priority by the adjudicators so that as many suspended bills as possible can be processed before the end of the payment cycle.

These bills will appear on the Remittance Advice mailed the following week with most bills processed to a paid or denied status. This does not mean that payment will be made on all bills. Electronic bills must pass the same Medical Aid Rules' requirements as paper bills. While you may not always receive payment, you will have a more timely answer in most cases to address non-payment.

The Future of Electronic Billing

Electronic transmission is rapidly becoming the preferred method of bill submission by both medical vendors and major medical payers. In Washington, Medicare, Blue Cross, the Department of Social and Health Services (Medicaid), and the Department of Labor and Industries currently process medical bills electronically. Many private insurers are turning to electronic billing because of the inherent efficiencies.

Utilizing existing technology, electronic transfer of bills provides you with superior services. It allows the most efficient and economic use of staff and resources, giving the employers of Washington State the best value for their industrial insurance premium dollars.

The success of electronic billing at Labor and Industries has increased the efficiency of bill processing and helped the department to pay providers in a more timely manner. Currently, over 50 percent of all medical bills are received by electronic means.

If you have additional questions regarding electronic billing or electronic remittance advice, contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512.

Getting Started

There are several options available for providers to submit bills electronically:

If you have a computer in your office, you can purchase a commercially available software program. The bill data must be formatted according to L&I specifications. If you currently are using a total office or practice management program, you should contact your software vendor to see if there is an electronic billing option available to work with your existing program.

or

You may elect to have a program specifically tailored to your system. If you wish to have a customized program written for you, refer to L&I's file specifications in the following chapter. We will answer any questions regarding the use of the file formats and work with you and your programmer to ensure the output of your program meets department requirements. Check your local Yellow Pages under "Computers - Software & Services" or "Computers - System Designers" for a programmer or developer in your area.

or

If you do not have a computer and still would like to benefit from electronic billing, you can employ the services of an electronic billing intermediary or data processing agent. They can submit the bills for you. There are several of these billing services available statewide. Check your local Yellow Pages under "Billing Services" or "Data Processing Services".

Your professional organization may be able to provide information regarding other providers' resources that are billing electronically.

All providers are required to submit a signed Electronic Billing Authorization to the Department prior to billing electronically. Before mailing to us, please make a copy for yourself (and your intermediary, if you use one). We will notify you when you are set up in our system to bill electronically.

Data Transfer Essentials and Options

Verify you received the correct specifications for your bill type. There are three separate specifications: UB92, for Hospital Inpatient and Outpatient services; HCFA-1500, for all providers' services including Miscellaneous and Vocational bill types; and Drug, for pharmacies billing prescription drugs by NDC.

Once your bill data is formatted to department specifications there are three methods of getting the data to us:

- Mail a disk
- Mail a CD-RW
- Transmit the file via modem directly to the Labor and Industries Bulletin Board System

We recommend you establish a submission schedule. We encourage you to submit bills in non-cutoff weeks to avoid the rush. Submitting bill files early in the payment cycle allows time for re-submission if there is a problem with your bill data.

Modem Transmission

Modem transmission gives you the greatest control over when your bill data will be received and processed by L&I.

Transmitting to Wildcat Bulletin Board System (BBS) Requirements:

ASYNC (serial port)
Modem with baud rate up to 38400
Communications software
Voice grade phone line
Settings: Parity = 8-none-1
Emulation = VT100 or ANSI

Communications protocol options available:

ASCII
Xmodem
Ymodem
Zmodem
Xmodem/1K
Xmodem/CRC

There are no scheduled transmission times. The lines are not toll-free; however, all phone lines are available 24 hours a day, seven days a week, including holidays. We do reserve the right to bring the systems down for maintenance when necessary.

Disks

- Disks can be formatted with either MS or PC DOS, double or high density.
- A reusable CD-RW is preferred over a read-only CD-R.

Mail disks to:

Department of Labor and Industries
Attn. Electronic Billing Unit
PO Box 44264
Olympia WA 98504-4264

For Federal Express or United Parcel Service mail to:

Department of Labor and Industries
MIPS/Electronic Billing Unit
7273 Linderson Way
Tumwater WA 98501

They will be returned to you with verification the bills have been processed. If there is a rejection, you will be notified by phone immediately to enable you to correct and resubmit your bill data.

Testing

Call our Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 to arrange testing. If you will be transmitting to our Wildcat BBS, we will establish a logon ID and password prior to submitting your first test.

Whichever method you choose to submit your electronic bills, we will work with you and your programmer to resolve any bill format problems during testing. This will ensure your bills will process smoothly through our Medical Information Payment System (MIPS).

The first submission should be a test file of five to ten bills. Please call either of the above-mentioned numbers for more specific information on testing procedures prior to submitting test data.

Submitting Live Data

Prior to submitting live bill data, please ensure that:

- You have completed an Electronic Billing Authorization and received a phone call notifying you that our system is ready to accept your electronic submission.

- **Third party intermediaries only:** You have been assigned a submitter number. (L&I assigns submitter numbers to third party intermediaries only.) Each of your clients must have completed an Electronic Billing Authorization for each facility allowing them to bill electronically. The Billing Authorization includes a section designating you to submit bills on their behalf.

- You have completed testing successfully.

Reporting Requirements

Current billing instructions require that reports be submitted separately from bills so that they can be made available to claims management as well as bill payment staff. Electronic transfer does not alter existing reporting requirements. **Do not submit reports to the Electronic Billing Unit.** Reports should be mailed to the following address:

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Introduction

This section describes the technical requirements for the submission of institutional bills in an electronic media format. The following is based on the Medicare Hospital Manual "Billing Procedures, Addendum A - Provider Electronic Billing File and Record Formats" section with some modifications for the Department of Labor and Industries. The record specifications themselves have NOT been modified except to bold L&I required fields. Please also see the L&I specific format instructions at the back of this manual.

1. File Specifications - 3 1/2" diskette or CD-RW

Record Code - American Standard Code for Information Interchange (ASCII)

File Label - None

Physical Record Length - 192 characters

File Name – i.e., 0012345I.001. Provider number plus "I" for inpatient or "O" for outpatient with Julian-date extension.

2. File Specifications – Telecommunications

File Label - None

Physical Record Length - 192 characters

Record Code - American Standard Code for Information Interchange (ASCII)

Baud Rate - up to 38400

File name – same as above.

3. Record Specifications --- The logical claim record is made up of a series of 192-character physical records. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20 - 29
Subset 2 - Third Party Data - Record Codes 30 - 39
Subset 3 - Claim Request Data - Record Codes 40 - 49
Subset 4 - Inpatient Accommodations Data - Record Codes 50 - 59
Subset 5 - Ancillary Services Data - Record Codes 60 - 69
Subset 6 - Medical Data - Record Codes 70 - 79
Subset 7 - Physician Data - Record Codes 80 - 89

The record layouts that follow will provide the following data:

1. Record Name: The name of the data record.
2. Record Type: Code indicating the type of record.
3. Record Size: Physical length of record. Constant 192.
4. Field Number
5. Field Name
6. Picture: This will be the COBOL picture. **Pic X will be initialized to blanks** and **Pic 9 will be initialized to zeros**. All money fields and date fields will be Pic 9. All code fields that have a legitimate value of zero will be Pic X. This will make it possible to detect whether a field has been omitted.
7. Field Specification: This indicates how the data field is justified.
   L = Left Justification, and
   R = Right Justification.
8. Position: From = leftmost position in the record (high order).
   Thru = rightmost position in the record (low order).

All fill fields are reserved for national use unless otherwise specified.

5. Key to Records

Record Name	**Record Type Code**
Processor Date	01
Additional Coordination of Benefits (COB) Information	02
Reserved for National Assignment	03-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Non-insured Employment Information	21
Unassigned State Form Locators	22
Reserved for National Assignment	23-24
Local Use	25-29
Third Party Payer Data	30-32
Reserved for National Assignment	33
Authorization	34
Local Use	35-39
Claim Data TAN-Occurrence	40
Claim Data Condition – Value	41

Record Name	Record Type Code
*Claim Change Reason Code	42
Reserved for National Assignment	43-44
Local Use	45-49
IP Accommodations Data	50
*IP – Amount Paid by Primary Payer	51
Reserved for National Assignment	52-54
Local Use	55-59
IP Ancillary Service Data	60
Outpatient Procedures	61
*IP – Ancillary Services Data – Amount Paid by Primary Payer	62
*Outpatient Procedures	63
*Ancillary or OP Reason Codes	64
Local Use	65-69
Medical Data	70
Plan of Treatment and Patient Information	71
Specific Services and Treatments	72
Plan of Treatment/Medical Update Narrative	73
Patient Information	74
Medical Documentation for Ambulance Claims	75
ESRD Medical Documentation	76
Plan of Treatment for Outpatient Rehabilitation	77
Reserved for National Assignment	78
Local Use	79
Physician Data	80
Pacemaker Registry Record	81
Reserved for National Assignment	82-84
Local Use	85-89
Claim Control Screen	90
Remarks (Overflow from RT 90)	91
*Claim Control Totals	92
Reserved for National Assignment	93-94
Provider Batch Control	95
Local Use	96-97
*Provider Chain Control	98
File Control	99

***COB Specific Records**

UB92 Format for Electronic Claims
Record Type 01 - Processor Data

Record Layouts

- Must be first record on file.
- Must be followed by RT 10.

Note:

Files will be formatted so that this is a **data** record, not a conventional label. From a system standpoint, this will be a 'labelless' file.

The processor data record will be the first record on each file.

This record indicates, in fields 5 through 7, the class and identification of the organization designated to receive this file or transmission. If the code in field 5 is a "Z", the file contains records for multiple primary payers. In this case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this transmission. Otherwise, the code in field 5 designates the types of primary payer. Field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for Medicaid, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this transmission. For Blue Cross Plans this field will be used as designated by the Plan receiving the file.

It is recommended that you and other billers establish a protocol limiting a file to a single disk. In the event a file exceeds that limit, the disk must end in a batch control (record type (RT) 95).

UB92 Format for Electronic Claims
Record Type 01 – Processor Data

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type "01"**	**X(2)**	**L**	**1**	**2**
2	**Submitter EIN**	**9(10)**	**R**	**3**	**12**
3	Multiple Provider Billing File Indicator	9		13	13
4	Filler (National Use)	X(17)	L	14	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	9(5)	R	32	36
7	Receiver Sub-Identification	X(4)	L	37	40
8	Filler (National Use)	X(6)		41	46
9	Submitter Name	X(21)	L	47	67
	Submitter Address Fields 10-13				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	X(2)	L	101	102
13	ZIP Code	X(9)	L	103	111
14	Submitter FAX Number	9(10)	R	112	121
15	Country Code	X(4)	L	122	125
16	Submitter Phone Number	9(10)	R	126	135
17	File Sequence & Serial Number	X(7)	L	136	142
18	Test/Production Indicator	X(4)	L	143	146
19	Date of Receipt (CCYYMMDD) (intermediary use only)	9(8)	R	147	154
20	**Processing Date (date bill submitted on HCFA 1450) (CCYYMMDD)**	**9(8)**	**R**	**155**	**162**

*Version 050
See Footnote C-1 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 01 – Processor Data
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
21	Filler (Local Use)	X(27)		163	189
22*	Version Code 050	X(3)	L	190	192

*Version 050
See Footnote C-1 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 10 – Provider Data

- Must follow either RT 01 or 95.
- Must be followed by RT 20 or RT 74. RT 20 is used when submitting billing record. RT 74 is used only when attachment information is being sent independent of the claim.

Note: This record must be present for each provider batch combination.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '10'**	**X(2)**	**L**	**1**	**2**
2	**Type of Batch**	**X(3)**	**L**	**3**	**5**
3	Batch Number	9(2)	R	6	7
4	Federal Tax Number or EIN	9(10)	R	8	17
5	Federal Tax Submitter ID	X(4)	L	18	21
6	National Provider Identifier	X(13)	L	22	34
7	Medicaid Provider Number	X(13)	L	35	47
8	CHAMPUS Insurer Provider Number	X(13)	L	48	60
9	**Other Insurer Provider Number**	**X(13)**	**L**	**61**	**73**
10	Other Insurer Provider Number	X(13)	L	74	86
11	Provider Phone Number	9(10)	R	87	96
12	**Provider Name**	**X(25)**	**L**	**97**	**121**
	Provider Address fields 13-16				
13	Address	X(25)	L	122	146
14	City	X(14)	L	147	160
15	State	X(2)	L	161	162
16	ZIP Code	X(9)	L	163	171
17	Provider FAX Number	9(10)	R	172	181
18	Country Code	X(4)	L	182	185
19	Filler (National Use)	X(4)		186	189
20	Filler (State Use)	X(3)		190	192

See Footnote C-2l for benefit coordination.

UB92 Format for Electronic Claims
Record Types 20-2N - Patient Data

- Must follow RT 10, RT 90 or RT 91.
- Must be followed by RT 21-2N or RT 30.
- All records following up through RT 90 must have the same patient control number.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '20'**	**X(2)**	**L**	**1**	**2**
2	Filler (National Use)	X(2)		3	4
3	**Patient Control Number**	**X(20)**	**L**	**5**	**24**
	Patient Name fields 4-6				
4	**Last Name**	**X(20)**	**L**	**25**	**44**
5	First Name	X(9)	L	45	53
6	Middle Initial	X		54	54
7	**Patient Sex**	**X**		**55**	**55**
8	**Patient Birthdate (CCYYMMDD)**	**9(8)**	**R**	**56**	**63**
9	Patient Marital Status	X		64	64
10	**Type of Admission**	**X**		**65**	**65**
11	Source of Admission	X		66	66
	Patient Address fields 12-16				
12	Address – Line 1	X(18)	L	67	84
13	Address – Line 2	X(12)	L	85	96
14	City	X(15)	L	97	111
15	State	X(2)	L	112	113
16	ZIP Code	X(9)	L	114	122
17	**Admission/Start of Care Date (CCYYMMDD)**	**9(8)**	**R**	**123**	**130**
18	Admission Hour	X(2)	L	131	132
19	Statement Covers Period **From (CCYYMMDD)**	**9(8)**	**R**	**133**	**140**
20	**Thru (CCYYMMDD)**	**9(8)**	**R**	**141**	**148**

UB92 Format for Electronic Claims
Record Types 20-2N – Patient Data
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
21	**Patient Status**	**9(2)**	**R**	**149**	**150**
22	Discharge Hour	X(2)	L	151	152
23	Payments Received (Patient Line)	9(8)V99S	R	153	162
24	Estimated Amount Due (Patient Line)	9(8)V99S	R	163	172
25	Medical Record Number	X(17)	L	173	189
26	Filler (National Use)	X(3)		190	192

See Footnote C-3 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 21 – Non-Insured Employment Information

- Must follow RT 20.
- Must be followed by RT 21-2N or RT 30.
- This record contains employment information pertaining to individuals not claiming insurance, but who may have some insurance coverage through their employer from which the patient may be eligible for benefits.
- There are four different individuals to whom this may apply: the patient, the patient's spouse, the patient's father, and the patient's mother. If more than two of these individuals are involved in this claim, use a second record type 21 to submit the relevant employment data for the third, and if applicable, the fourth party involved. The sequence number (field 2) of the second record type 21 is shown as "02".

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '21'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Employment Information - Packet One				
4	Employer Name	X(24)	L	25	48
	Employer Location – fields 5-8				
5	Employer Address	X(18)	L	49	66
6	Employer City	X(15)	L	67	81
7	Employer State	X(2)	L	82	83
8	Employer ZIP Code	X(9)	L	84	92
9	Employment Status Code	9		93	93
9a	Employer Qualifier (COB only)	99	R	94	95
10	Filler (National Use)	X(13)		96	108
	Employment Information - Packet Two				
11	Employer Name	X(24)	L	109	132
	Employer Location – fields 12-15				
12	Employer Address	X(18)	L	133	150
13	Employer City	X(15)	L	151	165
14	Employer State	X(2)	L	166	167
15	Employer ZIP Code	X(9)	L	168	176

UB92 Format for Electronic Claims
Record Type 21 – Non-Insured Employment Information
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
16	Employment Status Code	9		177	177
16a	Employer Qualifier (COB only)	9(2)	R	178	179
17	Filler (National Use)	X(13)		180	192

See Footnote C-4 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 22 – Unassigned State Form Locators

- Not required by Medicare.
- Assignment and/or use of these form locators is the responsibility of individual State Uniform Billing Committees (SUBC).
- The state code in field 4 is used to identify the SUBC responsible for the definition of the form locators on this sequence of RT 22.
- Must follow RT 20 or 21.
- Must be followed by RT 30.
- Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '22'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
4	State Code	X(2)	L	25	26
5	Form Locator 2 (upper line)	X(29)	L	27	55
6	Form Locator 2 (lower line)	X(30)	L	56	85
7	Form locator 11 (upper line)	X(12)	L	86	97
8	Form Locator 11 (lower line)	X(13)	L	98	110
9	Form Locator 56 (upper line)	X(13)	L	111	123
10	Form Locator 56 (2nd line)	X(14)	L	124	137
11	Form Locator 56 (3rd line)	X(14)	L	138	151
12	Form Locator 56 (4th line)	X(14)	L	152	165
13	Form Locator 56 (patient line)	X(14)	L	166	179
14	Form Locator 78 (upper line)	X(2)	L	180	181
15	**Form Locator 78 (lower line)**	**X(3)**	**L**	**182**	**184**
16	Filler (Local Use)	X(8)		185	192

See Footnote C-5 for benefit coordination.

UB92 Format for Electronic Claims
Record Types 30-3N – Third Party Payer

One third-party-payer record packet (record types 30-3N) must appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31, depending on the specific third party payer data required by the particular payer.

There is an optional RT 34 that contains detailed authorization information. If you require treatment or other authorization in advance of the beneficiary's receipt of services, issue an authorization number. If the authorization number is for a limited period of time, inform the provider of the applicable dates. If the authorization number applies to the entire claim, it is entered in RT 40 in the appropriate location for the payer issuing it. For further information regarding use of this record, see page A-15.

Example: Medicare is primary, and the secondary payer requires the insured's address.

	Record Type Code	Sequence Number
Medicare	30	01
Secondary Payer	30	02
Secondary Payer	31	02
Authorization	34	02

Because the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, it serves as a matching criterion for the specific third party payer record packet.

Sequence 01 represents the primary payer, sequence 02 represents the secondary payer, and sequence 03 represents the tertiary payer.

- May be followed by RT 30, 31, 34, or 40.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '30'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
4	Source of Payment Code	X		25	25
5-6	Payer Identification	X(9)	L	26	34
7	**Certificate/SocSecNumber/Health Insurance Claim/Identification Number**	**X(19)**	**L**	**35**	**53**
8a	Payer Identification Indicator	X(2)	L	54	55
8b	Payer Name	X(23)	L	56	78
9	Payer Code	X		79	79
10	**Insurance Group Number**	**X(17)**	**L**	**80**	**96**

UB92 Format for Electronic Claims
Record Types 30-3N – Third Party Payer
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
11	Insured Group Name	X(14)	L	97	110
	Insured's Name – fields 12-14				
12	Last Name	X(20)	L	111	130
13	First Name	X(9)	L	131	139
14	Middle Initial	X		140	140
15	Insured's Sex	X		141	141
16	Release of Information Certification Indicator	X		142	142
17	Assignment of Benefits Certification Indicator	X		143	143
18	Patient's Relationship to Insured	9(2)	R	144	145
19	Employment Status Code	9		146	146
20	Covered Days	9(3)	R	147	149
21	Non-Covered Days	9(4)	R	150	153
22	Co-insurance Days	9(3)	R	154	156
23	Lifetime Reserve Days	9(3)	R	157	159
24	Provider Identification Number	X(13)	L	160	172
25	Payments Received	9(8)V99S	R	173	182
26	Estimated Amount Due	9(8)V99S	R	183	192

See Footnote C-6 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 31 – Third Party Payer Data

- May follow RT 30 or 31.
- May be followed by RT 31, 34, or 40.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '31'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Insured's Address fields 4-8				
4	Address – Line 1	X(18)	L	25	42
5	Address – Line 2	X(12)	L	43	54
5a	Filler	X(6)	L	55	60
6	City	X(15)	L	61	75
7	State	X(2)	L	76	77
8	ZIP Code	X(9)	L	78	86
9	Employer Name	X(24)	L	87	110
	Employer Location fields 10-13				
10	Employer Address	X(18)	L	111	128
11	Employer City	X(15)	L	129	143
12	Employer State	X(2)	L	144	145
13	Employer ZIP Code	X(9)	L	146	154
14	Form Locator 37 (ICN/DCN)	X(23)	L	155	177
15	Contract Number	X(5)	L	178	182
16	Filler (National Use)	X(10)		183	192

See Footnote C-7 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 32 – Third Party Payer Data

- May follow RT 30 or 31.
- May be followed by RT 31, 34, or 40

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '32'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Payer Name	X(25)	L	25	49
	Payer Address fields 5-9				
5	Address	X(18)	L	50	67
6	Address	X(18)	L	68	85
7	City	X(15)	L	86	100
8	State	X(2)	L	101	102
9	ZIP Code	X(9)	L	103	111
10	Filler (National Use)	X(81)		112	192

See Footnote C-8 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 34 – Authorization

For routine use of a treatment authorization number that applies to the entire claim, use RT 40, Claim-TAN-Occurrence. For authorizations requiring dates, i.e., limited to a particular period of time, HCPCS or revenue codes use RT 34, Authorization. Use the same sequence numbers for RT 34 as are used for RT 30. The sequence 01 record must refer to the primary payer, Payer A. The sequence 02 must refer to the secondary payer, Payer B. The sequence 03 must refer to the tertiary payer, Payer C.

Use RT 34 when revenue code 624 is used in RT 60 or 61 to report investigation device exemption number (IDE). If multiple IDEs are RT 60 or 61, the first is described in fields 4-9, the second in field 10, the third in field 11, and the fourth in field 12.

Should you need to show authorization for only the secondary payer, complete a RT 34 for sequence 02 only. Do not complete a RT 34 for Payer A, sequence 01.

Use the revenue code and/or HCPCS procedure code to match the appropriate line item.

- May follow RT 30, 31, or 34.
- May be followed by RT 34 or 40.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '34'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Authorization – 1	X(45)	L	25	69
4	Authorization Type	X(2)	L	25	26
5	Authorization Number/IDE Number	X(18)	L	27	44
6	Authorization From Date (CCYYMMDD)	9(8)	R	45	52
7	Authorization Thru Date (CCYYMMDD)	9(8)	R	53	60
8	Authorization Revenue Code	9(4)	R	61	64
9	Authorization HCPCS Procedure Code	X(5)	L	65	69
10	Authorization – 2/IDE Number	X(45)	L	70	114
11	Authorization – 3/IDE Number	X(45)	L	115	159
12	Filler (National Use)	X(33)	L	160	192

See Footnote C-9 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 40-4N – Claim Data
Record Type 40 = Claim Data TAN-Occurrence
Record Type 41 = Claim Data Condition-Value

Generally, a claim contains a single set of type 40 and type 41 records. Each claim must contain a RT 40. The set may or may not contain a RT 41, depending on the information being submitted. (If there are no condition or value codes to report for the particular claim, there is no need for a RT 41.) However, if one set is not sufficient to contain all iterations of a particular coding structure, e.g., more than 12 value codes are required, submit additional iterations of the appropriate record type, 40 or 41, to convey the additional codes.

For RTs 40 and 41, sequence numbers 02 or higher, all fields except the field or fields required to convey the additional code or codes that could not be contained on the sequence 01 record are initialized to zeroes or blanks as appropriate, with the exception of the Record Type, Sequence, and Patient Control Number fields.

It is conceivable that a claim may require as many as 3 sequences of Claim-TAN-Occurrence and only 1 of Condition-Value, or vice versa. This is acceptable.

Record Type 40 = Claim Data TAN-Occurrence

- May follow RT 30, 31, 34, or 40.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '40'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
4	**Type of Bill**	**X(3)**	**L**	**25**	**27**
	Treatment Authorization Code – repeats 3 times				
5	**Treatment Authorization Code – A**	**X(18)**	**L**	**28**	**45**
6	Treatment Authorization Code – B	X(18)	L	46	63
7	Treatment Authorization Code – C	X(18)	L	64	81
	Occurrence Code and Date – repeats 7 times				
8	**Occurrence Code – 1**	**X(2)**	**L**	**82**	**83**
9	**Occurrence Date – 1 (CCYYMMDD)**	**9(8)**	**R**	**84**	**91**
10	Occurrence Code – 2	X(2)	L	92	93
11	Occurrence Date – 2 (CCYYMMDD)	9(8)	R	94	101
12	Occurrence Code – 3	X(2)	L	102	103

Record Type 40 = Claim Data TAN-Occurrence

(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
13	Occurrence Date – 3 (CCYYMMDD)	9(8)	R	104	111
14	Occurrence Code – 4	X(2)	L	112	113
15	Occurrence Date – 4 (CCYYMMDD)	9(8)	R	114	121
16	Occurrence Code – 5	X(2)	L	122	123
17	Occurrence Date – 5 (CCYYMMDD)	9(8)	R	124	131
18	Occurrence Code – 6	X(2)	L	132	133
19	Occurrence Date – 6 (CCYYMMDD)	9(8)	R	134	141
20	Occurrence Code – 7	X(2)	L	142	143
21	Occurrence Date – 7	9(8)	R	144	151
	Occurrence Span Code & Dates – repeats 2 times				
22	Occurrence Span Code - 1	X(2)	L	152	153
23	Occurrence Span From Date - 1 (CCYYMMDD)	9(8)	R	154	161
24	Occurrence Span Thru Date – 1 (CCYYMMDD)	9(8)	R	162	169
25	Occurrence Span Code – 2	X(2)	L	170	171
26	Occurrence Span From Date – 2 (CCYYMMDD)	9(8)	R	172	179
27	Occurrence Span Thru Date – 2 (CCYYMMDD)	9(8)	R	180	187
28	Filler (National Use)	X(5)		188	192

Note:
If the code in the Occurrence Code field is over 69, the two date fields following that code are associated with it, and the field following the first date is zero. If the code indicated in the Occurrence Span code field is less than 70, only the Occurrence Span From Date is completed. The code and date is interpreted as an Occurrence Code.

Similarly, if the code in the Occurrence Code field is M0-Z9, the two date fields following that code are associated with it, and the field following the first date is zero. If the code indicated in the Occurrence Span code field is A1-L9, only the Occurrence Span From Date is completed. The code and date is interpreted as an Occurrence Code.

See Footnote C-10 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 41 – Claim Data Condition-Value

- May follow RT 40 or 41.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '41'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
	Condition Code – repeats 10 times				
4	**Condition Code - 1**	**X(2)**	**L**	**25**	**26**
5	**Condition Code - 2**	**X(2)**	**L**	**27**	**28**
6	**Condition Code - 3**	**X(2)**	**L**	**29**	**30**
7	**Condition Code - 4**	**X(2)**	**L**	**31**	**32**
8	**Condition Code - 5**	**X(2)**	**L**	**33**	**34**
9	**Condition Code - 6**	**X(2)**	**L**	**35**	**36**
10	**Condition Code - 7**	**X(2)**	**L**	**37**	**38**
11	Condition Code - 8	X(2)	L	39	40
12	Condition Code - 9	X(2)	L	41	42
13	Condition Code - 10	X(2)	L	43	44
14	Form Locator 31 (upper)	X(5)	L	45	49
15	Form Locator 31 (lower)	X(6)	L	50	55
	Value Code – repeats 12 times				
16	Value Code - 1	X(2)	L	56	57
17	Value Amount - 1	9(7)V99S	R	58	66
18	Value Code - 2	X(2)	L	67	68
19	Value Amount - 2	9(7)V99S	R	69	77
20	Value Code - 3	X(2)	L	78	79
21	Value Amount - 3	9(7)V99S	R	80	88

UB92 Format for Electronic Claims
Record Type 41 – Claim Data Condition-Value
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
22	Value Code - 4	X(2)	L	89	90
23	Value Amount - 4	9(7)V99S	R	91	99
24	Value Code - 5	X(2)	L	100	101
25	Value Amount - 5	9(7)V99S	R	102	110
26	Value Code - 6	X(2)	L	111	112
27	Value Amount - 6	9(7)V99S	R	113	121
28	Value Code - 7	X(2)	L	122	123
29	Value Amount - 7	9(7)V99S	R	124	132
30	Value Code - 8	X(2)	L	133	134
31	Value Amount - 8	9(7)V99S	R	135	143
32	Value Code - 9	X(2)	L	144	145
33	Value Amount - 9	9(7)V99S	R	146	154
34	Value Code - 10	X(2)	L	155	156
35	Value Amount - 10	9(7)V99S	R	157	165
36	Value Code - 11	X(2)	L	166	167
37	Value Amount - 11	9(7)V99S	R	168	176
38	Value Code - 12	X(2)	L	177	178
39	Value Amount - 12	9(7)V99S	R	179	187
40	Filler (National Use)	X(5)		188	192

See Footnote C-11 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 50 – IP Accommodations Data

- May be preceded by RT 40-4N or 50-5N.
- May be followed by RT 50-5N, 60, or 70.
- Accommodations must be entered in numeric sequence.
- The sequence number for record type 50 can go from 01 to 99, each such physical record containing four accommodations, thus making provision for reporting up to 396 accommodations on a single claim.

Accommodation Revenue Codes: 100 thru 21X

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '50'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
	Accommodations – occurs 4 times				
	Accommodations – 1	X(42)		25	66
4	**Accommodations Revenue Code**	**9(4)**	**R**	**25**	**28**
5	**Accommodations Rate**	**9(7)V99**	**R**	**29**	**37**
6	**Accommodations Days**	**9(4)**	**R**	**38**	**41**
7	**Accommodations Total Charges**	**9(8)V99S**	**R**	**42**	**51**
8	**Accommodations Non-Covered Charges**	**9(8)V99S**	**R**	**52**	**61**
9	Form Locator 49	X(4)	L	62	65
10	Filler (National Use)	X		66	66
11	**Accommodations – 2**	**X(42)**		**67**	**108**
12	**Accommodations – 3**	**X(42)**		**109**	**150**
13	**Accommodations - 4**	**X(42)**		**151**	**192**

See Footnote C-12 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 60 – IP Ancillary Services Data

- May be preceded by RT 40, 41, 50-5N or 60.
- May be followed by RT 60 or 70.
- The sequence number for record type 60 can go from 01***X*** to 99, each such physical record containing three inpatient ancillary service codes, thus making provision for reporting up to 297 inpatient ancillary services on a single claim.
- Write all sequences of RT 60.

Payer and Related Information Revenue Codes: Codes 010-099.

These codes may be reported in RT 60, but the amounts associated with them are not to be included in control totals for ancillaries in RTs 90 and 91.

Inpatient Ancillary Service Revenue Codes: Codes 220-99X.

Inpatient Ancillary Codes must be in code number sequence.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '60'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
	Inpatient Ancillaries – occurs 3 times				
	Inpatient Ancillaries – 1	X(56)		25	80
4	**Inpatient Ancillary Revenue Code. If Revenue Code is 624, then also use RT 34. If Revenue Code is 002X, then field 5 contains a HIPPS Rate Code.**	**9(4)**	**R**	**25**	**28**
5	HCPCS Procedure Code/HIPPS	X(5)	L	29	33
6	Modifier 1 (HCPCS & Physicians' Current Procedural Terminology (CPT™) code - 4)	X(2)	L	34	35
7	Modifier 2 (HCPCS & CPT™ code - 4)	X(2)	L	36	37
8	**Inpatient Ancillary Units of Service**	**9(7)**	**R**	**38**	**44**
9	**Inpatient Ancillary Total Charges**	**9(8)V99S**	**R**	**45**	**54**
10	**Inpatient Ancillary Non-Covered Charges**	**9(8)V99S**	**R**	**55**	**64**
11	Form Locator 49	X(4)	L	65	68
12*	Assessment Date (CCYYMMDD)	X(8)	L	69	76
12A	Filler (National Use)	X(4)		77	80

UB92 Format for Electronic Claims
Record Type 60 – IP Ancillary Services Data
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
13	**Inpatient Ancillaries - 2**	**X(56)**		**81**	**136**
14	**Inpatient Ancillaries - 3**	**X(56)**		**137**	**192**

*This RT 60 will be identical for versions 4.1 and 5.0. Field 12 must only be completed when Revenue Code 002X is used, otherwise leave blank.
See Footnote C-13 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 61 – Outpatient Procedures

- May be preceded by RT 40, 41, or 61.
- May be followed by RT 61-6N, 70, or 80.
- The sequence number for record type 61 can go from 01 to 99, each such physical record containing three procedure codes, thus making provision for reporting up to 297 procedures on a single claim.

Payer and related information Revenue Codes: Codes 010-099.

These codes may be reported in RT 61, but the amounts associated with them are not to be included in control totals for ancillaries in RTs 90 and 91.

Outpatient Ancillary Codes must be in code number sequence.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '61'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
	Revenue Center – occurs 3 times				
	Revenue Code 1	X(56)		25	80
4	**Revenue Code. If Revenue Code is 624, then also use RT 34.**	**9(4)**	**R**	**25**	**28**
5	**HCPCS Procedure Code**	**X(5)**	**L**	**29**	**33**
6	**Modifier 1 (HCPCS & CPT™ code - 4)**	**X(2)**	**L**	**34**	**35**
7	**Modifier 2 (HCPCS & CPT™ code - 4)**	**X(2)**	**L**	**36**	**37**
8	**Units of Service**	**9(7)**	**R**	**38**	**44**
9	Form Locator 49	X(6)	L	45	50
10	**Outpatient Total Charges**	**9(8)V99S**	**R**	**51**	**60**
11	**Outpatient Non-Covered Charges**	**9(8)V99S**	**R**	**61**	**70**
12	**Date of Service (CCYYMMDD)**	**9(8)**	**R**	**71**	**78**
13	Filler (National Use)	X(2)		79	80
14*	**Revenue Code – 2**	**X(56)**		**81**	**136**
15*	**Revenue Code - 3**	**X(56)**		**137**	**192**

*Revenue Codes 2 and 3 have the same format as fields 4-13 in Revenue Code 1.
See Footnote C-14 in the UB92 Flat File 5.0 manual for benefit coordination and usage.

UB92 Format for Electronic Claims
Record Type 70-7N – Medical Data

- May be preceded by RT 50, 60, or 61.
- May be followed by RT 7N, 80, or 90.

The sequence number for record type 70 can be 01 or 02. The 01 record is for the reporting of nine diagnoses and six procedures leaving filler (positions 170-192) for local use. Use an 02 record when reporting Form Locator 57 data.

Note: ICD-9-CM coding is required for all bill types. Do not report the decimal in the code. The ICD-9-CM diagnosis codes are assigned a COBOL picture of X. Format the actual code in one of four general ways.

If you report 99999, it translates to 999.99.
If you report V9999, it translates to V99.99.
If you report E9999, it translates to E999.9.
If you report M99999, it translates to M9999/9.

To determine the location of the decimal position and the potential number of decimal positions, it is necessary only to examine the high order (left most) position of the field.

Record Type 70 – Medical Data (Sequences 1 & 2)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Sequence 1				
1	**Record Type '70'**	**X(2)**	**L**	**1**	**2**
2	**Sequence Number**	**9(2)**	**R**	**3**	**4**
3	Patient Control Number	X(20)	L	5	24
4	**Principal Diagnosis Code**	**X(6)**	**L**	**25**	**30**
5	**Other Diagnosis code – 1**	**X(6)**	**L**	**31**	**36**
6	**Other Diagnosis code – 2**	**X(6)**	**L**	**37**	**42**
7	**Other Diagnosis code – 3**	**X(6)**	**L**	**43**	**48**
8	**Other Diagnosis code – 4**	**X(6)**	**L**	**49**	**54**
9	**Other Diagnosis code – 5**	**X(6)**	**L**	**55**	**60**
10	**Other Diagnosis code – 6**	**X(6)**	**L**	**61**	**66**
11	**Other Diagnosis code – 7**	**X(6)**	**L**	**67**	**72**
12	**Other Diagnosis code – 8**	**X(6)**	**L**	**73**	**78**
13	**Principal Procedure Code**	**X(7)**	**L**	**79**	**85**

UB92 Format for Electronic Claims
Record Type 70 – Medical Data (Sequences 1 & 2)
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
14	**Principal Procedure Date (CCYYMMDD)**	**9(8)**	**R**	**86**	**93**
15	**Other Procedure Code - 1**	**X(7)**	**L**	**94**	**100**
16	Other Procedure Date - 1 (CCYYMMDD)	9(8)	R	101	108
17	**Other Procedure Code - 2**	**X(7)**	**L**	**109**	**115**
18	Other Procedure Date - 2 (CCYYMMDD)	9(8)	R	116	123
19	**Other Procedure Code - 3**	**X(7)**	**L**	**124**	**130**
20	Other Procedure Date – 3 (CCYYMMDD)	9(8)	R	131	138
21	**Other Procedure Code - 4**	**X(7)**	**L**	**139**	**145**
22	Other Procedure Date - 4 (CCYYMMDD)	9(8)	R	146	153
23	**Other Procedure Code - 5**	**X(7)**	**L**	**154**	**160**
24	Other Procedure Date - 5 (CCYYMMDD)	9(8)	R	161	168
25	**Admitting Diagnosis Code**	**X(6)**	**L**	**169**	**174**
26	**External Cause of Injury (E-Code)**	**X(6)**	**L**	**175**	**180**
27	Procedure Coding Method Used	9		181	181
28	Filler (National Use)	X(11)		182	192

See Footnote C-15 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 70 – Medical Data (Sequences 1 & 2)
(continued)

- Must follow RT 70, sequence 01.
- May be followed by RT 71-73, 75, 76, 77 or 80.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Sequence 2				
1	Record Type '70'	X(2)	L	1	2
2	Sequence	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Form Locator 57	X(27)	L	25	51
5	Filler (National Use)	X(141)		52	192

UB92 Format for Electronic Claims
Record Type 71-74 – Home Health Data Elements for Medical Review of Home Health Claims

- May be preceded by RT 10, 70, or 71.
- May be followed by RT 7N, 80, or 90.
- If being sent, RT 74 must be independent of claim.

Record Type 71 – Plan of Treatment and Patient Information
Record Type 72 – Specific Services and Treatments
Record Type 73 – Plan of Treatment/Medical Update Narrative
Record Type 74 – Patient Information

For use by HHAs to submit data from forms HCFA-485 and HCFA-486. Data is required when requested by the RHHI. RTs 71, 72, and 73 must be present. However, when submitting data from the HCFA-486 only (i.e., on interim claims), providers complete only the following fields on RT 71: Fields 1-6, 24-26, and 28-31. Zeroes are present in numeric fields and blanks in alphanumeric fields that do not contain data.

Data for the electronic forms HCFA-485 and HCFA-486 (i.e., RT 71-73) submitted separately from claim data must be in a batch containing RT 10. RT10, field 2 (Type of Batch) must contain "3M blank" to identify that the batch contains only attachment data. A RT 74 must be submitted for each unique patient in a 3M batch. The RT 74 replaces the
RT 20 for patient data in a 3M batch.

Providers must retain signed copies of the HCFA-485 and HCFA-486 in their files. The Provider Representative Certification must be submitted with the initial batch of claims containing the HCFA-485 and HCFA-486 data elements. Subsequent certifications are to be submitted in accordance with Hospital Manual §499.1.

See Footnote C-15 for benefit coordination and usage.

RECORD TYPE PLAN 71 – PLAN OF TREATMENT AND PATIENT INFORMATION

- May follow RT 70, 71 or 74.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '71'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3*	Patient Control Number	X(20)	L	5	24
4*	Data ID	X		25	25
5*	SOC Date (CCYYMMDD)	9(8)	R	26	33
	Certification Period				
6*	From (CCYYMMDD)	9(8)	R	34	41
7*	To (CCYYMMDD)	9(8)	R	42	49
8*	Date of Onset or Exacerbation of Principal Diagnosis (CCYYMMDD)	9(8)	R	50	57

Record Type Plan 71 – Plan of Treatment and Patient Information

(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
9*	Surgical Procedure Code	X(7)	L	58	64
10*	Date Surgical Procedure Performed (CCYYMMDD)	9(8)	R	65	72
	Dates of Onset/Exacerbation of Secondary Diagnosis – Occurs 2 times				
11*	Date Secondary Diagnosis – 1	9(8)	R	73	80
12*	Date Secondary Diagnosis – 2	9(8)	R	81	88
13*	Functional Limitation Code – occurs 10 times	X(10)	L	89	98
14*	Activities Permitted Code – occurs 10 times	X(10)	L	99	108
15*	Mental Status Code – occurs 5 times	X(5)	L	109	113
16*	Prognosis	X	L	114	114
17*	Verbal SOC Date (CCYYMMDD)	9(8)	R	115	122
18	Attending Physician's Last Name	X(16)	L	123	138
19	Attending Physician's First Name	X(8)	L	139	146
20	Attending Physician's Initial	X	L	147	147
21	Attending Physician's ZIP Code	X(9)	L	148	156
22	Medicare Covered	X		157	157
23*	Date Physician Last Saw Patient (CCYYMMDD)	9(8)	R	158	165
24*	Date Last Contacted Physician (CCYYMMDD)	9(8)	R	166	173
25	Patient Receiving Care in 1861 (j) (l) Facility	X		174	174
26	Cert/Recert/mod.	X		175	175
27*	Admission (CCYYMMDD)	9(8)	R	176	183
28*	Discharge (CCYYMMDD)	9(8)	R	184	191
29*	Type of Facility	X		192	192

*This denotes the data elements that are required for the abbreviated format for the HCFA-485/486.
See Footnote C-16 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 72 – Specific Services and Treatments

- May follow RT 71 or 72.
- May be followed by RT 72, 73, 74, 75, 76, 77, 80, or 90.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '72'	X(2)	L	1	2
2*	Sequence Number	9(2)	R	3	4
3*	Patient Control Number	X(20)	L	5	24
4*	Discipline	X(2)	L	25	26
5*	Visits (this bill) Related to Prior Certification	9(2)	R	27	28
	Frequency and Duration – Occurs 12 times				
6*	Frequency and Duration - 1	X(6)		29	34
	Frequency Number – 1	9	R	29	29
	Frequency Period – 1	X(2)	L	30	31
	Duration - 1	X(3)	L	32	34
7*	Frequency and Duration - 2	X(6)		35	40
8*	Frequency and Duration - 3	X(6)		41	46
9*	Frequency and Duration - 4	X(6)		47	52
10*	Frequency and Duration - 5	X(6)		53	58
11*	Frequency and Duration - 6	X(6)		59	64
12*	Frequency and Duration - 7	X(6)		65	70
13*	Frequency and Duration - 8	X(6)		71	76
14*	Frequency and Duration - 9	X(6)		77	82
15*	Frequency and Duration - 10	X(6)		83	88
16*	Frequency and Duration - 11	X(6)		89	94
17*	Frequency and Duration - 12	X(6)		95	100

UB92 Format for Electronic Claims
Record Type 72 – Specific Services and Treatments
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Treatment Codes – Occurs 25 times	X(75)	L	101	175
18*	Code - 1	X(3)	L	101	103
19*	Code - 2	X(3)	L	104	106
20*	Code - 3	X(3)	L	107	109
21*	Code - 4	X(3)	L	110	112
22*	Code - 5	X(3)	L	113	115
23*	Code - 6	X(3)	L	116	118
24*	Code - 7	X(3)	L	119	121
25*	Code - 8	X(3)	L	122	124
26*	Code - 9	X(3)	L	125	127
27*	Code - 10	X(3)	L	128	130
28*	Code - 11	X(3)	L	131	133
29*	Code - 12	X(3)	L	134	136
30*	Code - 13	X(3)	L	137	139
31*	Code - 14	X(3)	L	140	142
32*	Code - 15	X(3)	L	143	145
33*	Code - 16	X(3)	L	146	148
34*	Code - 17	X(3)	L	149	151
35*	Code - 18	X(3)	L	152	154
36*	Code - 19	X(3)	L	155	157
37*	Code - 20	X(3)	L	158	160
38*	Code - 21	X(3)	L	161	163
39*	Code - 22	X(3)	L	164	166
40*	Code - 23	X(3)	L	167	169

UB92 Format for Electronic Claims
Record Type 72 – Specific Services and Treatments
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
41*	Code - 24	X(3)	L	170	172
42*	Code - 25	X(3)	L	173	175
43*	Total Visits Projected this Cert.	9(2)	R	176	177
44	Filler (National Use)	X(7)		178	184
45	Filler (Local Use)	X(8)		185	192

*This denotes the data elements that are required for the abbreviated format for the HCFA-485/486.
See Footnote C-17 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 73 – Plan of Treatment/Medical Update Narrative

This record(s) contains narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information". This record is used to provide information requested on the HCFA-485/486 and to elaborate on any item on the forms. The HHA should **not provide narrative instead of completing fields** on RTs 71 and 72. Complete a separate RT 73 for each item. As many RT 73s as necessary are used. A sequence number is increased by one for each record present (i.e., 01-99). Listed below are items that may require a narrative record. An "R" is reflected for data that is always required.

Data Element	Data ID Number	Required Elements
Medications	48510	R
DME and Supplies	48514	Not required if no DME or supplies are billed
Safety Measures	48515	If present.
Nutritional Requirements	48516	R
Allergies	48517	If present.
Orders for Discipline and Treatments	48521	
Goals/Rehabilitation	48522	R
Potential/Discharge Plans – Updated Information	48616	R
Functional Limitations – Reason Homebound	48617	R
Supplementary Plan of Treatment	48618	If applicable.
Unusual Home/Social Environment	48619	If applicable.
Times and Reasons Patient Not at Home	48620	If affirmative.
Medical/Non-medical Reason Patient Leaves Home	48621	R

UB92 Format for Electronic Claims
Record Type 73 – Plan of Treatment/Medical Update Narrative
(continued)

- May follow RT 72 or 73.
- May be followed by RT 73, 74, 75, 76, 77, 80, or 90.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '73'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Filler (National Use)	X(2)		25	26
5	Data ID Number	X(5)	L	27	31
6	Corresponding Data	X(161)	L	32	192

See Footnote C-18 for benefit coordination and usage.

UB92 Format for Electronic Claims
Record Type 74 – Patient Information

This record is only used to give patient information when a provider submits attachment data (i.e., plan of treatment) independent from claim data. Each new RT 74 indicates a new and unique claim.

Attachment records (7X series) submitted separately must be in a batch submission containing RT 10 (Provider Batch Header Record) and RT 95 (Provider Batch Control). On RT 10, field 2, and RT 95, field 5, submitters enter Type of Batch "3M Blank" to identify that the batch contains only attachment data.

RT 74 is not required when Record Types 20, 30, 60, 61, and 70 are submitted. RT 74 must be in a file transmission with Record Types 01, 10, 90, 95, and 99.

If submitting home health agency data, Record Types 71, 72, and 73 must precede RT 74. If submitting ambulance, end stage renal disease facility, or rehabilitative services, Record Types 75, 76, or 77, respectively, must follow RT 74.

Providers must notify you and conduct testing, as appropriate, prior to submitting data separate from the claim.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '74'	X(2)	L	1	2
2	Filler (National Use)	X(2)		3	4
3	Patient Control Number	X(20)	L	5	24
4	Attachment Submission Status	X(20)	L	25	26
5	HICN	X(19)	L	27	45
6	Medical Record Number	X(17)	L	46	62
	Patient Name				
7	Last Name	X(20)	L	63	82
8	First Name	X(9)	L	83	91
9	Middle Initial	X		92	92
10	Patient Birthdate (CCYYMMDD)	9(8)	R	93	100
11	Patient Sex	X		101	101
12	Principal Diagnosis Code	X(6)	L	102	107
13	Other Diagnosis Code - 1	X(6)	L	108	113
14	Other Diagnosis Code - 2	X(6)	L	114	119
15	Other Diagnosis Code - 3	X(6)	L	120	125
16	Other Diagnosis Code - 4	X(6)	L	126	131

UB92 Format for Electronic Claims
Record Type 74 – Patient Information
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
17	Start of Care/Admission Date (CCYYMMDD)	9(8)	R	132	139
18	Statement Covers Period From Date (CCYYMMDD)	9(8)	R	140	147
19	Through Date (CCYYMMDD)	9(8)	R	148	155
20	Provider Number	X(13)	L	156	168
21	Internal Control/Document Control Number (ICN/DCN)	X(23)	L	169	191
22	Filler (National Use)	X		192	192

See Footnote C-19 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 75 – Medical Documentation for Ambulance Claims

- May be preceded by RT 40, 41, 50, 60, 70, 74, or 75.
- If not preceded by RT 40, 41, 50, 60, or 70, must be preceded by RT 74 or 75.
- May be followed by RT 75, sequence 2, RT 76, 77, 80, or 90.

Record type 75 us used by providers to submit medical documentation for ambulance claims. They may submit information with or without the billing record. When submitted without billing records, RT 74 is used to give patient information.

A single record to provide documentation for the following ambulance services reported on the billing record:

- A single trip.
- A round trip, origin to destination and return.
- Multiple trips if the origin and destination points are the same, or initial and return trips are the same.

Separate record for each ambulance trip(s) reported on the bill does not meet the above criteria.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Sequence 1				
1	Record Type ’75	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
	Reason for Ambulance Transportation (occurs 3 times)				
4	Reason 1 X(3)		L	25	27
5	Reason 2 X(3)		L	28	30
6	Reason 3 X(3)		L	31	33
7	Number of Trips	X(2)	L	34	35
	Pick-up Destination Code (occurs 2 times)				
8	Code 1 X(3)		L	36	38
9	Code 2 X(3)		L	39	41
10	Base Charge	9(5)V99S	R	42	48
11	Number of Miles	9(4)	R	49	52
12	Cost Per Mile	9(4)V99S	R	53	58

UB92 Format for Electronic Claims
Record Type 75 – Medical Documentation for Ambulance Claims
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Ancillary Charges				
13	Medical Surgical Supplies	9(4)V99S	R	59	64
14	IV Solutions	9(4)V99S	R	65	70
15	Oxygen/Oxygen Supplies	9(4)V99S	R	71	76
16	Injectable Drugs	9(4)V99S	R	77	82
	Pick-Up Address				
17	Place	X(18)	L	83	100
18	City	X(15)	L	101	115
19	State	X(2)	L	116	117
20	ZIP Code	X(9)	L	118	126
	Destination Address				
21	Name	X(20)	L	127	146
22	Place	X(18)	L	147	164
23	City	X(15)	L	165	179
24	State	X(2)	L	180	181
25	ZIP Code	X(9)	L	182	190
26	Filler	X(2)		191	192

UB92 Format for Electronic Claims
Record Type 75 – Medical Documentation for Ambulance Claims
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Sequence 2				
1	Record Type ’75	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Reason for Transfer	X(3)	L	25	27
5	Reason for Bypass of Nearest Facility	X(3)	L	28	30
6	Air Ambulance Justification	X(3)	L	31	33
7	Ancillary Charge Other	9(4)V99S	R	34	39
8	Remarks	X(153)	L	40	192

See Footnote C-20 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 76, Format L – ESRD Medical Documentation

- May be preceded by RT 40, 41, 50, 60, or 70.
- If not preceded by RT 40, 41, 50, 60, or 70, must be preceded by RT 74.
- May be preceded by RT 72, 73, 0r 75.
- May be followed by RT 76-M, 77, 80, or 90.

Record Type 76 is used by providers to submit medical documentation for ESRD facility claims. They may submit the information with, or independent of, claim data. If submitted independent of claim data, use RT 74 to give patient information.

If providers must provide information on more than 4 lab tests, they may repeat RT 76, format L, until the number of occurrences are met. All information on RT 76, Format L, should be completed before creating sequences of RT 76, Format M. All filler is for national use. Lab values have an implied decimal point after the fifth left position. For example, the largest field size is 99999.99.

Excepting fields 1 through 4 on RT 76, Formats L and M, all field requirements are at payer discretion. For Medicare, the requirement of submission for any individual field, except fields 1 through 4, is at intermediary discretion to meet medical review needs.

Additional narrative remarks needed to clarify information on RT 76 should be placed in RT 90 or RT 91, as appropriate.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '76'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Record Format Type – L	X		25	25
	Non-Routine and Separately Billable Lab Tests (occurs 1 to 4 times)				
5	HCPCS Code	X(5)	L	26	30
6	Modifier 1	X(2)	L	31	32
7	Modifier 2	X(2)	L	33	34
8	Previous Lab Value	9(7)	R	35	41
9	Date Previous Lab (CCYYMMDD)	9(8)	R	42	49
10	Current Lab Value	9(7)	R	50	56
11	Date Current Lab (CCYYMMDD)	9(8)	R	57	64
12	Lab Tests – Occurrence 2	X(39)	L	65	103

UB92 Format for Electronic Claims
Record Type 76, Format L – ESRD Medical Documentation
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
13	Lab Test – Occurrence 3	X(39)	L	104	142
14	Lab Test – Occurrence 4	X(39)	L	143	181
15	Filler (National Use)	X(11)		182	192

UB92 Format for Electronic Claims
Record Type 76, Format M – ESRD Medical Documentation

- May be preceded by RT 40, 41, 50, 60, or 70.
- If not preceded by RT 40, 41, 50, 60, or 70, must be preceded by RT 74.
- May be preceded by RT 72, 73, 75, or 76, Format L.
- May be followed by RT 77, 80, or 90.

If providers must provide information on additional medications, dialysis sessions, or other services than accommodated in this record layout, they may repeat RT 76, Format M, until number of occurrences is met. For an example of sequencing, see §3908.7.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '76'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Record Format Type – M	X		25	25
	Medication Administration (occurs 1 to 3 times)				
5	National Drug Code	X(11)	L	26	36
6	Drug Units	9(4)	R	37	40
7	Place of Administration	9		41	41
8	Route of Administration	9		42	42
9	Frequency and Duration	X(6)	L	43	48
10	Medication – Occurrence 2	X(23)	L	49	71
11	Medication – Occurrence 3	X(23)		72	94
	Extra Dialysis Session (occurs 1 to 3 times)				
12	Date of Extra Session (CCYYMMDD)	9(8)	R	95	102
13	Justification for Extra Session	9		103	103
14	Extra Dialysis – Occurrence 2	X(9)	L	104	112
15	Extra Dialysis – Occurrence 3	X(9)	L	113	121

UB92 Format for Electronic Claims
Record Type 76, Format M – ESRD Medical Documentation
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
	Other Services (occurs 1 to 3 times)				
16	HCPCS or CPT™ Code	X(5)	L	122	126
17	Date Previous Test/Service (CCYYMMDD)	9(8)	R	127	134
18	Date Current Test/Service (CCYYMMDD)	9(8)	R	135	142
19	Other Service – Occurrence 2	X(21)	L	143	163
20	Other Services – Occurrence 3	X(21)	L	164	184
21	Weight in Kg.	9(3)	R	185	187
22	Filler (National Use)	X(5)		188	192

See Footnote C-21 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 77 – Format A – Administrative Data Record

This record series (RT 77) supports information regarding a plan of treatment for outpatient rehabilitative services. It correlates to paper Forms HCFA-700 and -701. It may be sent with billing records or upon request by a payer or its intermediary. RT 77 was designed for use by the Medicare program. It may be used by other payers desiring the same rehabilitation services information. All sequences and fields of RT77 are reserved for national use.

Format A describes the provider of service and the attending physician. It may be repeated for multiple disciplines.

- May follow RT 77, format N (Rehabilitative Services Narrative Text) if multiple disciplines are being reported.
- Must be followed by RT 77, format R (Rehabilitative Services).

If submitted with claim:

- Must be preceded by Record Types 20, 30, 40, 61, and 70. RT 41 may precede RT 77 series. Record Types 80 and 90 must follow the RT 77 series. Record Types 01, 10, 95, and 99 must be included in the file submission.

If being submitted independent of claim:

- Must be preceded by RT 74 and followed by RT 90. Record Types 01, 10, 95, and 99 must be included in the file submission. RT 74 is required and indicates a new and unique claim.

Multiple rehabilitative disciplines can relate to one claim (identified by RT 20 or the ICN/DCN on RT 74), but new formats A and R must be created for each discipline. For example, if you request information about PT and OT services, two pairs of formats A and R must be included in the transaction. All records, including narrative formats, relating to a specific rehabilitative discipline (e.g., PT), should be created and grouped sequentially before proceeding to a new rehabilitative discipline (e.g., OT).

There is only one Format A and one Format R record for each discipline. They must occur in that order. Narrative records (Format N) follow Format R. When a second or subsequent discipline is necessary, the second or subsequent format A is submitted in sequence, followed by format R and, as necessary, Format N records.

For an example of the sequencing, see §3908.2.C.

UB92 Format for Electronic Claims
Record Type 77 – Format A – Administrative Data Record
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '77'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Record Format – A	X		25	25
5	Discipline Physician Information (fields 6-9)	X(2)	L	26	27
6	Attending Physician Identifier	X(16)	L	28	43
7	Physician Referral Date (CCYYMMDD)	9(8)	R	44	51
8	Physician Signature Date on Plan of Treatment (CCYYMMDD)	9(8)	R	52	59
	Rehabilitation Professional Information (fields 9-14)				
9	Rehab. Professional Identifier	X(16)	L	60	75
10	Rehab. Professional Name (Last)	X(20)	L	76	95
11	Rehab. Professional Name (First)	X(9)	L	96	104
12	Rehab. Professional Name (MI)	X		105	105
13	Professional Designation of Rehab. Professional	X(7)	L	106	112
14	Rehab. Professional Signature Date on Plan of Treatment (CCYYMMDD)	9(8)	R	113	120
	Prior Hospitalization Dates (From-Through) (Fields 15-19)				
15	From Date (CCYYMMDD)	9(8)	R	121	128
16	Through Date (CCYYMMDD)	9(8)	R	129	136
17	Date of Onset/Exacerbation of Principal Diagnosis (CCYYMMDD)	9(8)	R	137	144
18	Admission Date/Start Care Date (CCYYMMDD)	9(8)	R	145	152
19	Total Visits from Start of Care	9(4)	R	153	156

UB92 Format for Electronic Claims
Record Type 77 – Format A – Administrative Data Record
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
20	Date of Most Recent Event Requiring Cardiac Rehabilitation (CCYYMMDD)	9(8)	R	157	164
21	Treatment Diagnosis Code (ICD-9)	X(6)	L	165	170
22	Treatment Diagnosis (Narrative)	X(21)	L	171	191
23	Filler (National Use)	X		192	192

See Footnote C-22 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 77 – Format R – Rehabilitative Services Record

Format R describes the plan of treatment and certification for an outpatient rehabilitative service. It may be repeated for multiple disciplines.

Multiple rehabilitative disciplines can relate to one claim (identified by RT 20 or the ICN/DCN on RT 74), but formats A and R must be created for each discipline. For example, if you request information about PT and OT services, two pairs of formats A and R should be included in the transaction. All records, including narrative formats, relating to a specific rehabilitative discipline (e.g., PT) should be created and grouped sequentially before proceeding to a new rehabilitative discipline (e.g., OT).

There is only one Format A and Format R record for each discipline. They must occur in that order. Narrative records (format N) follow format R. When a second or subsequent discipline is necessary, the second or subsequent format A is submitted in a sequence, followed by format R and, as necessary, format N records.

Fields 19 through 23 are for optional use for psychiatric service.

- Must follow RT 77, format A.
- May be followed by RT 77, format N.

If submitted with claim:

- May be followed by RT 80.

If submitted independent of claim:

- May be followed by RT 90.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '77'	X(2)	L	1	2
2	Sequence Numbers	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Record Format – R	X		25	25
5	Discipline Plan of Treatment (POT) (fields 6-12)	X(2)	L	26	27
6	POT – Status (Initial/Update)	9(3)	R	28	30
7	POT – Date Established (CCYYMMDD)	9(8)	R	31	38
	POT – Period Covered (From-Through)				
8	From Date (CCYYMMDD)	9(8)	R	39	46
9	Through Date (CCYYMMDD)	9(8)	R	47	54

UB92 Format for Electronic Claims
Record Type 77 – Format R – Rehabilitative Services Record
(continued)

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
10	Frequency and Duration				
	Frequency Number	9		55	55
	Frequency Period	X(2)	L	56	57
	Duration	X(3)	L	58	60
11	Estimated Date of Completion of Outpatient Rehabilitation (CCYYMMDD)	9(8)	R	61	68
12	Service Status (Continue/Discontinue)	9		69	69
13	Certification Status	9(2)	R	70	71
14	Date of Last Certification (CCYYMMDD)	9(8)	R	72	79
15	Route of Administration – IM	X		80	80
16	Route of Administration – IV	X		81	81
17	Route of Administration – PO	X		82	82
18	Drug Administered (Narrative)	X(90)	L	83	172
19	Prognosis	X		173	173
20	Filler (National Use)	X(19)		174	192

See Footnote C-22 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 77 – Format N – Rehabilitative Services Record

Format N supports the submission of narrative text by provider.

- Must follow RT 77, format R.
- May be followed by RT 77, Format N (as directed below) and, as appropriate, to your information requests and requirements.
- May be followed by RT 77, Format A, if multiple rehabilitative disciplines are submitted.

If submitted with claim:

- May be followed by RT 80.

If submitted independent of claim:

- May be followed by RT 90.

The type of narrative records requested/required by you follows the needs and requirements of all MR processes. Specify the necessary narrative types. Encourage providers to limit the text to information pertinent to the current plan of treatment.

All narrative records for each discipline should be grouped sequentially before proceeding to a subsequent discipline, noted by a Format A record. For example, all PT narrative records should be completed before creating an OT sequence, beginning with a new Format A. All records of a specific narrative type (e.g., functional goals) must be grouped together in sequential order. For example, all plan of treatment narrative (narrative type 04) for PT should be completed before beginning records for progress report (narrative type 05) for PT.

Multiple sequences of specific narrative types may be repeated to accommodate text information. See §3908.2.C for example of sequencing. Narrative for an individual narrative type (e.g., 02 - initial assessment) can repeat up to but no more than (3) times for a total of 456 bytes of information, except narrative type 05 (progress report), which can repeat up to but no more than six (6) times for a total of 912 bytes of information.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '77'	X(2)	L	1	2
2	Sequence Number	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Record Format – N	X	L	25	25
5	Discipline	X(2)	L	26	27
6	Narrative Type Indicator	99	R	28	29
7	Free-Form Narrative	X(152)	L	30	181
8	Filler (National Use)	X(11)		182	192

See Footnote C-22 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 80-8N – Physician Data

- May be preceded by RT 70-7N.
- May be followed by RT 80, 81, or 90.

The sequence number for record type 80 can be 01-20. The 01 record is always for the primary payer. If the secondary payer uses a different physician identification numbering scheme from the primary payer, the provider shows the secondary payer's physician identification number on the 02-sequence record. If the tertiary payer uses a different physician identification numbering scheme from the primary or secondary payer, the provider shows the tertiary payer's physician identification number on the 03 sequence record. If a primary payer requests multiple physician numbers, sequence number 11 is used. If a secondary payer requests multiple physician numbers, sequence number 12 is used. If a tertiary payer requests multiple physician numbers, sequence number 13 is used. The sequences must match those on RT 30.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '80'	X(2)	L	1	2
2	Sequence	9(2)	R	3	4
3	Patient Control Number	X(20)	L	5	24
4	Physician Number Qualifying Codes	X(2)	L	25	26
5	Attending Physician Number*	X(16)	L	27	42
6	Operating Physician Number*	X(16)	L	43	58
7	Other Physician Number*	X(16)	L	59	74
8	Other Physician Number*	X(16)	L	75	90
9	Attending Physician Name**	X(25)	L	91	115
10	Operating Physician Name**	X(25)	L	116	140
11	Other Physician Name**	X(25)	L	141	165
12	Other Physician Name**	X(25)	L	166	190
13	Filler (National Use)	X(2)		191	192

**On Medicare claims, Physician Name is broken down as follows:

Last Name	Positions	1-16
First Name	Positions	17-24
Middle Initial	Position 25	

Physician Number Qualifying Codes:

UP UPIN
FI Federal Taxpayer's Identification Number
SL State License Number
SP Specialty License Number
X National Provider Identifier (NPI)

See Footnote C-23 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 90 – Claim Control Screen

- May be preceded by RT 50-5N, 60-6N, 70-7N, or 80-8N.
- Must be followed by RT 20, 74, 91, or 95.
- If more than 110 characters are required for Form Locator 84, use RT 91 to report the additional characters and code a "1" in field 12 of RT 90. A "0" indicates that no RT 91 follows.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '90'**	**X(2)**	**L**	**1**	**2**
2	Filler (National Use)	X(2)		3	4
3	Patient Control Number	X(20)	L	5	24
4	Physical Record Count (Excluding RT 90 + 91) Record Type nn Count (fields 5-11)	9(3)	R	25	27
5	Record Type 2n Count	9(2)	R	28	29
6	Record Type 3n Count	9(2)	R	30	31
7	Record Type 4n Count	9(2)	R	32	33
8	Record Type 5n Count	9(2)	R	34	35
9	Record Type 6n Count	9(2)	R	36	37
10	Record Type 7n Count	9(2)	R	38	39
11	Record Type 8n Count	9(2)	R	40	41
12	Record Type 91 Qualifier	9	R	42	42
13	**Total Accommodation Charges – Revenue Centers**	**9(8)V99S**	**R**	**43**	**52**
14	**Non-Covered Accommodation Charges – Revenue Centers**	**9(8)V99S**	**R**	**53**	**62**
15	**Total Ancillary Charges – Revenue Centers**	**9(8)V99S**	**R**	**63**	**72**
16	**Non-Covered Ancillary Charges – Revenue Charges**	**9(8)V99S**	**R**	**73**	**82**
17	**Remarks**	**X(110)**	**L**	**83**	**192**

See Footnote C-25 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 91 - Remarks

- Must be preceded by RT 90.
- Must be followed by RT 20, 74, or 95.
- The first 110 characters from Form Locator 84, Remarks, which are required to provide additional information on the claim, must be entered on RT 90. If more than 110 characters are required, use field 4 or RT 91 to report them.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	Record Type '91'	X(2)	L	1	2
2	Filler (National Use)	X(2)		3	4
3	Patient Control Number	X(20)	L	5	24
4	Remarks (additional)	X(82)	L	25	106
5	Filler (National Use)	X(86)		107	192

See Footnote C-26 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 95 – Provider Batch Control

- Must be preceded by RT 90 or 91.
- Must be followed by RT 10 or 99.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record Type '95'**	**X(2)**	**L**	**1**	**2**
2	Federal Tax Number (EIN)	9(10)	R	3	12
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Type of Batch	X(3)	L	22	24
6	**Number of Claims**	**9(6)**	**R**	**25**	**30**
7	Number of 3M Batch Attachment Records	9(6)	R	31	36
8	Accommodations Total Charges for Batch	9(10)V99S	R	37	48
9	Accommodations Non-Covered Charges for Batch	9(10)V99S	R	49	60
10	Ancillary Total Charges for Batch	9(10)V99S	R	61	72
11	Ancillary Non-Covered Charges for Batch	9(10)V99S	R	73	84
12	Total Charges for Batch (COB only)	V(10V99S	R	85	96
13	Total Non-Covered Charges for Batch (COB only)	9(10)V99S	R	97	108
14	Reserved for Future Use	X(12)	L	109	120
15	Filler (National Use)	X(18)		121	138
16	Filler (Local Use)	X(54)		139	192

See Footnote C-27 for benefit coordination.

UB92 Format for Electronic Claims
Record Type 99 – File Control

- Must be preceded by RT 95.
- Must be last valid record on file.

Field Number	Field Name	Picture	Field Specification	Position From	Position Thru
1	**Record type '99'**	**X(2)**	**L**	**1**	**2**
2	**Submitter EIN**	**9(10)**	**R**	**3**	**12**
3	Receiver Identification	9(5)	R	13	17
4	Receiver Sub-Identification	X(4)	L	18	21
5	Number of Batches Billed This File	9(4)	R	22	25
6	**Accommodations Total Charges for File**	**9(11)V99S**	**R**	**26**	**38**
7	Accommodations Non-Covered Charges for File	9(11)V99S	R	39	51
8	**Ancillary Total Charges for File**	**9(11)V99S**	**R**	**52**	**64**
9	Ancillary Non-Covered Charges for File	9(11)V99S	R	65	77
10	Total Charges for File (COB only)	9(11)V99S	R	78	90
11	Total Non-Covered Charges for File (COB only)	9(11)V99S	R	91	103
12	Number of Claims for File (COB only)	9(8)	R	104	111
13	Number of Records for File (COB only)	9(8)	R	112	119
14	Filler (National Use)	X(16)		120	135
15	Filler (Local Use)	X(57)		136	192

See Footnote C-28 for benefit coordination.

UB92 L&I Specific Format Instructions

Note: Unless otherwise indicated, instructions apply to both inpatient and outpatient bills.

Required Field	Field Description/Comments
Record Type 01 - Processor Data	
1	Record Type '01'
2	Submitter EIN - Seven-digit submitter number assigned by L&I. L&I will pick up the last seven digits in this field. If you are acting as a third party intermediary, you must apply for an intermediary submitter number.
20	Processing Date "Date Claim (Bill) Submitted" on HCFA 1450 (CCYYMMDD)
Record Type 10 - Provider Data	
1	Record Type '10'
2	Type of Batch Values: I = Inpatient O = Outpatient
9	Other Insurer Provider Number - Seven digit provider account number assigned byL&I. L&I will pick up the first 7 digits in this field. Leading zeros are required.
12	Provider Name
Record Type 20 - 2N - Patient Data	
1	Record Type '20'
3	Patient Control Number - Patient account number. L&I will pick up the first twelve characters in this field. This number will be reported on the remittance advice.
4	Patient Last Name
7	Patient Sex - (Required for inpatient only)

Required Field	Field Description/Comments
8	Patient Birthdate (Required for inpatient only) (Format CCYYMMDD)
10	Type of Admission (Required for inpatient only)
17	Admission Hour/Start of Care Date (Required for inpatient only)(CCYYMMDD)
19	Statement Covers Period From (CCYYMMDD)
20	Statement Covers Period Thru (CCYYMMDD) - The thru date of service must be entered as well as the from date of service (field 19), even if they are the same.
21	Patient Status - (Required for inpatient only)

Record Type 21 - Noninsured Employment Information

Record Type 21 contains no required fields.

Record Type 22 - Unassigned State Form Locators

1	Record Type '22'
2	Sequence Number
15	Form Locator 78 (lower line) - Side of body code for principal diagnosis code. Values: R = Right L = Left B = Both Blank = not applicable

Record Type 30 - 3N - Third Party Payer Data

1	Record Type '30'
2	Sequence Number - Use sequence number 1
7	Certificate/SocSecNumber/Health Insurance Claim/Identification Number-Worker's Social Security Number
10	Insurance Group Number - Claim Number assigned by L&I, consisting of seven characters. L&I will pick up the first seven characters in this field.

Required Field	Field Description/Comments

Record Type 31 - Third Party Payer Data

Record Type 31 contains no required fields.

Record Type 32 - Third Party Payer Data

Record Type 32 contains no required fields.

Record Type 34 - Authorization

Record Type 34 contains no required fields.

Record Type 40 - 4N - Claim Data
Record Type 40 = Claim (Bill) Data TAN-Occurrence

1	Record Type '40'
2	Sequence Number
4	Type of Bill - Use the 3-digit code for Claim (Bill) type.
5	Treatment Authorization Code-A - Treatment authorization code assigned by L&I's utilization review firm. (Required for inpatient and outpatient)
8	Occurrence Code - 1 - Use Code '04'. Code 04 - Accident/employment related.
9	Occurrence Date - 1 - Date of injury. (Format - CCYYMMDD)

Record Type 41 = Claim Data Condition-Value

1	Record Type '41'
2	Sequence Number
4	Outpatient only, required if applicable.
5	Outpatient only, required if applicable.
6	Outpatient only, required if applicable.
7	Outpatient only, required if applicable.

8	Outpatient only, required if applicable.

Required Field	Field Description/Comments
9	Outpatient only, required if applicable.
10	Outpatient only, required if applicable.

Record Type 50 - IP Accommodations Data

1	Record Type '50'
2	Sequence Number - Use sequence number 01 for the first Record Type 50 for this claim (bill), 02 for the second Record Type 50 for this claim (bill), etc. up to a maximum of 99 line items (combination of record types 50 and 60).
4	Accommodations Revenue Code
5	Accommodations Rate - Cannot exceed $99999.99. Do not enter decimal.
6	Accommodations Days - Enter the number of days accommodations in whole numbers. Do not use fractions or decimal.
7	Accommodations Total Charges - Total cannot exceed $99999.99. Do not enter negative amounts. Do not enter decimal.
8	Accommodations Non-Covered Charges - Totals cannot exceed $99999.99. Do not enter negative amounts. Do not enter decimal.
11	Accommodations -2- Required if applicable. Do not enter decimal. Do not enter negative amounts.
12	Accommodations -3- Required if applicable. Do not enter decimal. Do not enter negative amounts.
13	Accommodations - 4- Required if applicable. Do not enter decimal. Do not enter negative amounts.

Notes:

- Required for inpatient claims (bills) only.
- Between records 50 and 60, L&I can only accommodate up to a total of 99 revenue/HCPC codes on a single claim (bill).

Required Field	Field Description/Comments

Record Type 60 - IP Ancillary Services Data

1	Record Type '60'
2	Sequence Number - Use sequence number 01 for the first Record Type 60 for this claim (bill), 02 for the second Record Type 60 for this claim (bill), etc., up to a maximum of 99 line items (combination of Record Types 50 and 60 for inpatient claims (bills).
4	Inpatient Ancillary Revenue Code
8	Inpatient Ancillary Units of Service - Enter the number of units in whole numbers. Do not use fractions or decimals.
9	Inpatient Ancillary Total Charges - Do not enter decimal. Do not enter negative amounts. Total cannot exceed $99999.99.
10	Inpatient Ancillary Non-Covered Charges - Do not enter decimal. Do not enter negative amounts. Totals cannot exceed $99999.99.
13	Inpatient Ancillaries - Required if applicable.
14	Inpatient Ancillaries - Required if applicable.

Notes:

- Required for inpatient claims (bills) only.
- Between records 50 and 60, L&I can only accommodate up to a total of 99 codes on a single claim (bill).

Record Type 61 - Outpatient Procedures

1	Record Type '61'
2	Sequence Number - Use sequence number 01 for the first Record Type 60 for this claim (bill), 02 for the second Record Type 60 for this claim (bill), etc., up to a maximum of 99 line items (combination of Record Types 60 and 61).
4	Revenue Center Code
5	HCPCS Procedure Code
6	Modifier 1 – Outpatient only, required if applicable.

7 Modifier 2 – Outpatient only, required if applicable.

Required Field	Field Description/Comments
8	Units of Service - Enter the number of units in whole numbers. Do not use fractions or decimals.
10	Outpatient Total Charges - Total cannot exceed $99999.99. Do not enter decimal. Do not enter negative amounts.
11	Outpatient Non-Covered Charges - Total cannot exceed $99999.99. Do not enter decimal. Do not use negative amounts.
12	Date of Service – required.
14	Revenue Center - 2
15	Revenue Center - 3

Notes:

- Required for outpatient claims (bills) only.
- L&I can accommodate up to a total of a combination of 99 revenue/procedures on a single claim (bill).

Record Type 70 - 7N - Medical Data, Sequence 1

1	Record Type '70'
2	Sequence
4	Principal Diagnosis Code
5	Other Diagnosis Code - 1 - Required if applicable. Do not include decimal.
6	Other Diagnosis Code - 2 - Required if applicable. Do not include decimal.
7	Other Diagnosis Code - 3 - Required if applicable. Do not include decimal.
8	Other Diagnosis Code - 4 - Required if applicable. Do not include decimal.
9	Other Diagnosis Code - 5 - Required if applicable. Do not include decimal.
10	Other Diagnosis Code - 6 - Required if applicable. Do not include decimal.
11	Other Diagnosis Code - 7 - Required if applicable. Do not include decimal.

Required Field	Field Description/Comments
12	Other Diagnosis Code - 8 - Required if applicable. Do not include decimal.
13	Principal Procedure Code - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
14	Principal Procedure Date (CCYYMMDD) - Required for inpatient and outpatient, if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
15	Other Procedure Code - 1 - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
17	Other Procedure Code - 2 - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
19	Other Procedure Code - 3 - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
21	Other Procedure Code - 4 - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
23	Other Procedure Code - 5 - Required for inpatient and outpatient if applicable. Outpatient effective dates of service 4/25/94 and after. Do not include decimal.
25	Admitting Diagnosis Code - Do not include decimal.
26	External Cause of Injury (E-Code) - Do not include decimal.

♦ **Note**: Record Type 70 - Sequence 2 contains no required fields.

Record Type 71 - Plan of Treatment and Patient Information

Record Type 71 contains no required fields.

Record Type 72 - Specific Services and Treatments

Record Type 72 contains no required fields.

Record Type 73 - Plan of Treatment/Medical Update Narrative

Record Type 73 contains no required fields.

Required Field	Field Description/Comments

Record Type 74 - Patient Information

Record Type 74 contains no required fields.

Record Type 75 – Medical Documentation for Ambulance Claims

Record Type 75 contains no required fields.

Record Type 76 – Format L –ESRD Medical Documentation

Record Type 76 Format L contains no required fields.

Record Type 76 – Format M–ESRD Medical Documentation

Record Type 76 Format M contains no required fields.

Record Type 77 – Format A- Administrative Data Record

Record Type 77 Format A contains no required fields.

Record Type 77 – Format R- Rehabilitative Services Record

Record Type 77 Format R contains no required fields.

Record Type 77 – Format N- Rehabilitative Services Record

Record Type 77 Format N contains no required fields.

Record Type 80 - 8N- Physician Data

Record Type 80 contains no required fields.

Record Type 90 - Claim Control Screen

1	Record Type '90'
13	Total Accommodations Charges - Revenue Centers The sum of accommodations total charges in field 7 of all Records Type 50 for this claim (bill). Do not use decimals. Do not enter negative amounts. Required for inpatient only.

Required Field	Field Description/Comments
14	Non-Covered Accommodations Charges - Revenue Centers The sum of non-covered accommodations total charges in field 8 of all Records Type 50 for this claim (bill). Do not use decimals. Do not enter negative amounts. Required for inpatient only.
15	Total Ancillary Charges - Revenue Centers Inpatient Claim (Bill) - The sum of inpatient ancillary total charges in field 9 of Records Type 60 for this claim (bill). Outpatient Claim (Bill) - The sum of outpatient total charges in field 10 of all Records Type 61 for this claim (bill). Do not use decimals. Do not enter negative amounts.
16	Non-Covered Ancillary Charges Inpatient Claim (Bill) - The sum of inpatient ancillary Non-Covered charges in field 10 of all Records Type 60 for this claim (bill). Outpatient Claim (Bill) - The sum of outpatient Non-Covered charges in field 11 of all Records Type 61 for this claim (bill). Do not use decimals. Do not enter negative amounts.
17	Remarks - Inappropriate use of the remarks field will cause your claim (bill) to unnecessarily suspend. Please see the special instructions section of this packet. L&I will pick up the first 40 characters of this field. Beginning December 8, 1997, valid remarks must begin with an @.

Note:

- Total claim (bill) charge cannot exceed $9999999.99

Record Type 91 - Remarks

Record Type 91 contains no required fields.

Record Type 95 - Provider Batch Control

1	Record Type '95'
6	Number of Claims (Bills) - Count of each sequence of Records Type 20 – 90.

Record Type 99 - File Control

1	Record Type '99'
2	Submitter EIN - Seven-digit submitter number assigned by L&I. L&I will pick up the last seven digits in this field. Required for inpatient only.

Required Field	Field Description/Comments
6	Accommodations Total Charges for the File - The sum of accommodations total charges in field 7 of all Records Type 50 must equal the total accommodation charges in field 13 of Record Type 90. Do not use decimal. Do not enter negative amounts. Required for inpatient only.
8	Ancillary Total Charges for the File - The sum of inpatient ancillary total charges in field 9 of all Records Type 60 and outpatient total charges in field 10 of all Records Type 61 must equal the sum of total ancillary charges in field 15 of Record Type 90. Totals cannot exceed $9999999.99. Do not use decimals. Do not enter negative amounts.

Note:

- Unless otherwise indicated, instructions apply to both inpatient and outpatient services.

Special Instructions for Electronic Billing

Reporting Requirements

Electronic billing does not alter the existing reporting requirements for L&I. **All services currently requiring reports continue whether bills are submitted electronically or on paper.** Providers should continue to mail reports separately from the billing to the following address:

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Backup Documentation for All Bills

The following supporting documentation is required for all Inpatient and Outpatient bills:

- Admission history and physical examination (inpatient only)
- Discharge summary for stays over 48 hours (inpatient only)
- Operative reports (inpatient and outpatient)
- Emergency room reports (inpatient and outpatient)

The injured worker's name and claim number must be in the upper right hand corner of each page of documentation.

Re-bills

Previously denied bills or those that paid at $0.00 may be re-billed electronically. **Do not** indicate "re-bill" or the ICN of the original bill in the remarks field. It is not necessary to send backup documentation again when re-billing

Adjustments

Adjustments cannot be billed electronically. If a bill has been paid in error or if you wish reconsideration of the amount paid, you must submit a paper Provider's Request for Adjustment form (F245-183-000).

Use of the Remarks Field

A message of up to 40 characters may be entered in the Remarks/Detail Narrative Comments field. **Improper use of the remarks field can cause unnecessary delay in the payment of your bills.** MIPS will suspend any bill which has data keyed in the Remarks field so that it may be manually adjudicated based upon the remarks. Remarks such as routine descriptions of procedure or diagnosis codes or the results of diagnostic studies should **not** be entered in this field, nor should requests for authorization of services. **To enter valid remarks (i.e., multiple modifiers) you must key an @ as the first character of your remarks (e.g., @-51, -62).**

Required Remarks

In some cases, further explanation of services rendered is required in the remarks field. The following situations are examples:

Procedure codes referencing an unlisted service -
Indicate the nature of the service.

Procedure codes having the following modifiers -
22 - Explain the nature of the additional charges.
99 - Indicate all applicable modifiers.

Optional Remarks

Appropriate use of the Remarks field is not limited to those messages indicated above. If you are in question of what may be appropriate, please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512.

Who to Call

Your Software Vendor or Intermediary

Call your software vendor:

- When you have problems with the program itself.
- For answers regarding which fields to use, where to key something, the different screens available for use on your system, etc.

Call your intermediary:

- Regarding the timing of bill submissions to L&I.

Electronic Billing Unit

(360)902-6511 or (360)902-6512
Available Monday - Friday, 8:00 a.m. - 5:00 p.m.

What the Electronic Billing Unit can do for you:

- Answer technical questions regarding your electronic bill submission, test files, or if you have a problem during transmission and want to verify your file was received.
- Answer any questions regarding file specifications, trouble-shoot electronic bill file problems.
- Arrange testing for new users.
- Establish a user account to allow you access to the L&I Bulletin Board System (Wildcat BBS) for transmitting bill files via modem.

The Claim Information System

1-800-831-5227
Available Monday - Friday, 6:00 a.m. - 7:00 p.m.

What information is available:

- Claim numbers
- Diagnoses
- Procedures
- Drug restrictions
- Basic status information
- Hospital Authorization Numbers

What you need:

- Touch-tone telephone
- Your provider number
- Claim number or patient's Social Security Number
- Date of injury

You can request additional information regarding this service by calling the Provider Hotline.

Provider Hotline

1-800-848-0811
Available Monday - Friday, 8:00 a.m. - 5:00 p.m.

What the provider hotline staff can do for you:

- Authorize routine services for a claim.
- Verify whether specific services or procedures have been authorized.
- Answer general questions about billing procedures, bill processing, and claim status.
- Explain EOB codes or why bills denied or are "in process".
- Check how many bills are in process and verify warrant amounts.
- If a question requires additional research or authorization by the claims adjudication staff, they can send a priority message to the claims unit or the bill payment staff.
- Verify an impatient or outpatient authorization number, if the services have already been authorized.

Utilization Review Notification

The Department's HOSTPIAL INPATIENT/OUTPATIENT UTILIZATION REVIEW (UR) PROGRAM was implemented in July, 1988. The program includes:

- Prior authorization for inpatient admissions & targeted outpatient surgical & diagnostic procedures.
- Length of stay and continued stay evaluation for inpatient admission.
- Discharge coordination.
- Case management.

Admitting physicians must call the Department's UR firm to request an authorization number for an inpatient admission prior to all non-emergent, elective hospital inpatient stays, including these admissions:

- Exceptions to the Department's mandatory outpatient surgery program.
- Rehabilitation treatment (other than inpatient pain clinic treatment).
- Psychiatric treatment.
- Targeted outpatient procedures.

Providers are required to comply with the Department's inpatient pre-admission review program. If circumstances prevent a call prior to admission, please call as early as possible during the admission, as concurrent review may still be possible. Failure to verify authorization may result in delayed or denied payment.

To request current copies of Provider Bulletins explaining the policies of our hospital pre-admission review program, please call (360) 902-6799.

Our Utilization Review Notification Lines are nationwide: Phone: 1-800-541-2894

Fax: (360) 754-4991

Receiving the Electronic Remittance Advice

The Electronic Remittance Advice comes in the format specified in the following section. Your programmer or vendor supporting your electronic billing software may be able to assist you in making use of this option.

When you are ready to begin receiving the Electronic Remittance Advice, simply notify our office at 360-902-6511 or -6512. We will verify that your provider account is already established to bill electronically, then we will update your account to generate your electronic remittance advice. You will receive your remittance advice both on hardcopy and electronically (i.e., 3.5-inch disk or CD-RW). If you would like your intermediary to receive your Electronic Remittance Advice, you must sign and notarize the Power of Attorney for this designation. Return it to the following address:

Department of Labor and Industries
Electronic Billing Unit
PO Box 44264
Olympia WA 98504-4264

In order to receive your Electronic Remittance Advice you will need to provide our office with approximately 3 disks of either type. These will be used exclusively for your data. Please label them externally with your name and address. We will mail your Electronic Remittance Advice on a bi-weekly basis in coordination with the department payment cycle.

All correspondence pertaining to the Electronic Remittance Advice and disks can be sent to the address above.

If you have questions regarding the Electronic Remittance Advice, please contact the Electronic Billing Unit at 360-902-6511 or -6512.

Electronic Remittance Advice Record Format
Inpatient Header Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"I1"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Remittance Advice Number	11	19	9(9)	
Payment Date	20	25	9(6)	MMDDYY
Provider Number	26	32	9(7)	
Claim Number	33	39	X(7)	
Claimant Name	40	63	X(24)	
Internal Control Number	64	80	9(17)	
Filler	81	160	X(80)	

Notes:

- First record for each bill.
- Followed by "I2" record.
- All "X" fields are left justified.
- All "9" fields are right justified.
- All records are 160 bytes.
- Files received on disk are ASCII.
- Files will be sent with filenames consisting of your submitter ID with the Julian date extension on which the RA was generated. Note: there may be multiple files.

Electronic Remittance Advice Record Format
Inpatient Service Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"I2"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Line Number	11	12	X(2)	
First Date of Service	13	18	9(6)	MMDDYY
Last Date of Service	19	24	9(6)	MMDDYY
DRG Indicator	25	25	X(1)	D = DRG
Revenue Code	26	29	X(4)	
Procedure Code	30	34	X(5)	
Units of Service	35	41	9(7)	
Line Item Charge	42	49	9(6)V99	
Line Item Allowed	50	57	9(6)V99	
Line Item Non-Covered or Tax	58	65	9(6)V99	
Line Item Payable	66	73	9(6)V99	
Line Item EOB (1)	74	76	X(3)	
Line Item EOB (2)	77	79	X(3)	
Filler	80	160	X(81)	

Notes:

- Follows "I1" record.
- Followed by "I3" record for each bill.

Electronic Remittance Advice Record Format
Inpatient Trailer Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"I3"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Total Charge	11	19	9(7)V99	
Non-Covered Charge	20	28	9(7)V99	
Net Charge	29	37	9(7)V99	
Third Party Payment	38	46	9(7)V99	
Total Payable Amount	47	55	9(7)V99	
Bill EOB Code (1)	56	58	X(3)	
Bill EOB Code (2)	59	61	X(3)	
Status of Bill	62	62	X(1)	P = Paid D = Denied R = Returned I = In Process
Type of Bill	63	63	X(1)	I = Inpatient
Patient Account Number	64	83	X(20)	
Filler	84	160	X(77)	

Notes:

- Follows "I2" record for each bill.
- May be followed by "I1" record for next bill or by "99" record to end file.

Electronic Remittance Advice Record Format
Provider Trailer Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"99"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Submitter Number	11	17	9(7)	
Filler	18	160	X(143)	

Notes:

- Follows "I3" record; ends file.

Electronic Remittance Advice Record Format
Outpatient Header Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"O1"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Remittance Advice Number	11	19	9(9)	
Payment Date	20	25	9(6)	MMDDYY
Provider Number	26	32	9(7)	
Claim Number	33	39	X(7)	
Claimant Name	40	63	X(24)	
Internal Control Number	64	80	9(17)	
Filler	81	160	X(80)	

Notes:

- First record for each bill.
- Followed by "O2" record.
- All "X" fields are left justified.
- All "9" fields are right justified.
- All records are 160 bytes.
- Files received on disk are ASCII.
- Files will be sent with filenames consisting of your submitter ID with the Julian date extension on which the RA was generated. Note: there may be multiple files.

Electronic Remittance Advice Record Format
Outpatient Service Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"O2"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Line Number	11	12	X(2)	
First Date of Service	13	18	9(6)	MMDDYY
Last Date of Service	19	24	9(6)	MMDDYY
Revenue Code	25	28	X(4)	
Procedure Code	29	33	X(5)	
Modifier 1	34	35	X(2)	
Modifier 2	36	37	X(2)	
Modifier 3	38	39	X(2)	
Modifier 4	40	41	X(2)	
APC	42	46	X(5)	
Units of Service	47	53	9(7)	
Line Item Charge	54	60	9(5)V99	
Line Item Allowed	61	67	9(5)V99	
Line Item Non-Covered or Tax	68	74	9(5)V99	
Line Item Payable	75	81	9(5)V99	
Line Item EOB (1)	82	84	X(3)	
Line Item EOB (2)	85	87	X(3)	
Filler	88	160	X(73)	

Notes:

- Follows “O1” record.
- Followed by “O3” record for each bill.

Electronic Remittance Advice Record Format
Outpatient Trailer Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"O3"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Total Charge	11	19	9(7)V99	
Non-Covered Charge	20	28	9(7)V99	
Net Charge	29	37	9(7)V99	
Outlier Payment	38	46	9(7)V99	
Third Party Payment	47	55	9(7)V99	
Total Payable Amount	56	64	9(7)V99	
Bill EOB Code (1)	65	67	X(3)	
Bill EOB Code (2)	68	70	X(3)	
Status of Bill	71	71	X(1)	P = Paid D = Denied R = Returned I = In Process
Type of Bill	72	72	X(1)	O = Outpatient
Patient Account Number	73	92	X(20)	
Filler	93	160	X(68)	

Notes:

- Follows "O2" record for each bill.
- May be followed by "O1" record for next bill or by "99" record to end file.

Electronic Remittance Advice Record Format
Provider Trailer Record

Field	Position Start	End	Picture	Comments
Record Code	1	2	X(2)	"99"
Media	3	3	X(1)	1 = Disk 2 = PC 3 = Disk & Hardcopy 4 = PC & Hardcopy
Payee Number	4	10	9(7)	
Submitter Number	11	17	9(7)	
Filler	18	160	X(143)	

Notes:

- Follows "O3" record; ends file.

State of Washington
County of _____

Power of Attorney

KNOW ALL PERSONS BY THESE PRESENT, that the undersigned,

_____ of _____ County, Washington does hereby

make, constitute and appoint_____ as attorney in fact
(name of intermediary)
for the benefit of the undersigned, and in its name, place and stead for the following purposes:

To act as an agent for the undersigned in receiving the undersigned's Industrial Insurance remittance advice by electronic means from the Washington State Department of Labor and Industries Medical Information and Payment System. The remittance advice information will contain itemized detail of bills processed by the Medical Information and Payment System, including billed charges, allowed charges, payable charges, explanation of denied charges or partial payments, and a listing of those bills still in process as of the close of the processing cycle.

This Power of Attorney is made effective this ____ day of _____, 20____.

_____ _____

L&I Provider Number Notary Public

_____

L&I Provider Number

By:_____